

FOSTER GRANDPARENT PROGRAM
APPLICATION FORM

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Medicare #: _____

Medicaid #: _____ Married: _____ Single: _____ Widowed: _____ Divorced: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Number of children: _____ Number of grandchildren: _____ Number of great-grandchildren: _____

Where did you first hear about the Foster Grandparent Program? _____

What makes you feel you would be a successful Foster Grandparent? _____

Have you ever worked with children? If so, where? _____

Major previous occupation? _____

List hobbies/special skills: _____

Highest grade completed in school? _____ Can you read and write? _____

Do you have your own means of transportation? _____ If so would you be willing to transport

Foster Grandparents? _____ Do you have a chronic illness or disability? _____ If so,

explain: _____

List any medication you are required to take: _____

List your preference for hours of work (ex: 8:00am – 12:00) _____

List two character references that are not relatives:

Name	Address	Phone
------	---------	-------

Name	Address	Phone
------	---------	-------

Personal Physician & Address: _____

Who to notify in case of emergency: _____ Relationship: _____

Address: _____

Automobile Insurance Information

Drivers License #: _____ Expiration Date: _____

Names of Insurance Co.: _____

Policy #: _____ Name of Policy Holder: _____

Beneficiary of FGP Insurance

Name

Address

Phone

I consent to the use by ACTION and/or FGP of my photographic likeness in pictures take for any and all purposes of said agencies, including publication of public information and recruitment purposes.

I understand that if I use my personal automobile in my volunteer service, I will arrange to keep in effect my driver's license and automobile liability insurance equal to the minimum limits required by our state.

In connection with my volunteer activities as a Foster Grandparent, I agree to hold all information I may have access to about consumers or former consumers confidential and will not divulge any information to unauthorized persons. I understand that the divulging of confidential information to unauthorized persons will make me subject to either civil action for the collection of monetary damages and/or suspension or dismissal.

Sources of Income (Monthly Amounts!)	Yourself	Spouse's	Other Household Income	Total
Social Security				
V A Benefits				
SSI				
Retirement Plan(s)				
Rental Income				
Interest Income				
Income / Odd Jobs				
Inheritance (cash)				
Other cash income				
Grand Total				

Number of persons living in your home? _____

I certify that to the best of my knowledge all income has been stated for the next 12 months and is correct. Also, I have read the above statements and hereby agree.

X _____
Signature Date

DO NOT WRITE IN THE SPACE FOR FGP USE ONLY

I certify the NCDL has been verified and they do have a current NCDL or NC State ID and I have verified they are age eligible for the program. Initial _____ Date _____

Transportation _____
Mileage _____
Income _____
Interviewed _____

X _____
(Signature of FGP Volunteer Coordinator)

(Date)

Please return this form to: Community Services, FGP Program, PO Box 560, Raleigh, NC 27602